

Request form



VITAL MEDICAL SUPPLIES
(A Division of EBOS Group Pty Ltd)

Please note: A current Vital account is required before a scheduled account can be created.
Failure to complete this form correctly will result in a delay in setting up your account.

Existing Vital Account Number: _____ (must be provided)

Please select ONE of the below:

Multiple requests will require multiple forms

- Upgrade** account to receive scheduled items
*Account must already exist
- Change** the authorised practitioner or delivery address
*Account must already exist
- Open a scheduled** sub account for an alternative delivery address
*Linked to your existing account
- Open a Non-scheduled** sub account for an alternative delivery address
*Linked to your existing account, the requestor of this request can sign the form.
- Open** a Schedule 8 account
*Please also complete Signatory Acknowledgement form provided and attach a valid medical registration or licence
- Open** a “vaccine only” account
*For Nurse Immunisers – include a letter from employer confirming employment as a Nurse Immuniser or a Nurse Immuniser card

The principle place of practice and delivery point for scheduled and non-scheduled products will be:

**Please complete even if remaining unchanged*

Account Name					
Street Address					
Suburb		State		Postcode	
Contact Phone		Add to online	Yes or No (Please circle)		

In order for your Scheduled request to be processed you must send through:

Not required for Non- Scheduled requests

- This form completed in full, signed and dated by the Authorised Practitioner or Licence Holder
- A copy of your Medical Registration or licence to obtain relevant scheduled drugs.
 - If previously provided on another account, please advise account # _____

Copies of Medical Registrations printed from www.ahpra.gov.au cannot be accepted unless they are signed by the authorised practitioner. Provider Numbers are not accepted.

Declaration: I am authorised to purchase scheduled medicines as requested above and confirm that all information provided is true and accurate. I also confirm my authority has NO current restrictions, notations or reprimands. (If your authorisation contains restrictions, notations or reprimands, please list and attach them on a separate page).

Please return form to: Email: database@vitalmed.com.au

Fax: 1300 557 631

Authorised Practitioner Name: _____ Date: _____

Authorised Practitioner Signature: _____